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EDITORIAL

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Concomitant sleep disorders—a reason for in-clinic sleep studies in patients with obstructive sleep apnea?

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In their article, Steven Scharf and co-workers [1] present retrospective data for the prevalence of concomitant sleep disorders in 643 patients with a primary diagnosis of obstructive sleep apnea (OSA) out of 1,162 consecutive patients referred for polysomnography.

The fact that 31% OSA patients had concomitant sleep disorders, and out of these 22.6% had either inadequate sleep hygiene or periodic limb movement disorder (PLMD) might not be very surprising to insiders. However, the fact that 12.5% had other sleep disorders than the two mentioned above might be of major political importance. Or to quote the authors of the paper: "The question of the role of the sleep specialist and polysomnographer in the evaluation of patients with sleep-disordered breathing is impacted by these findings".

On 21 September 2004 the Federal Board of Physicians and Public Health Care Insurances in Germany passed a federal law that polysomnography in OSA patients should be performed in an ambulant, out-patient status and reimbursed by the public health care fundings of the ambulant system for physicians in private practice (depending on the area, this means a reimbursement of 250–300 € per polysomnography for pulmonary specialists, neurologists, etc. in private practice). In-clinic sleep laboratories immediately received letters from some public health care insurances that their polysomnographies in OSA patients will not be reimbursed in the future.

In the past we, the progressive fraction of sleep specialists (not to mention the English and Scotish Extremists), have pushed for the evidence-based, low-cost and simple method approach in sleep medicine. Do we have the pendulum pushed too far? Maybe!

It is probably a law of nature that health insurances go for a maximum of cost reduction, no matter what.

It is now our duty as sleep scientists to bring that pendulum back to the middle, where we actually, even the progressive group, wanted it to be.

The data by Steven Scharf and his co-workers proves to me that not all those classified simply as OSA patients might be that simple as previously guessed. Adding heart disease patients with periodic breathing (left out intentionally in the actual study) into the equation would enlarge the number of difficult patients even more.

The diagnosis and treatment of the concomitant sleep disorders like narcolepsy and insomnia requires definitely special sleep medicine knowledge, which can—in combination with the necessary knowledge for the respiratory part—not be delivered by just one specialist in private practice. One of the conclusions of the actual study might therefore be that the days of the good old in-clinic sleep laboratory with an array of inter-disciplinary working sleep specialists are not yet over.

Reference

1. Scharf SM, Tubman A, Smale P (2005) Prevalence of concomitant sleep disorders in patients with obstructive sleep apnea. Sleep Breath DOI 10.1007/s11325-005-0014-1